

Health Information Technology Commission
Minutes

Date: Thursday, September 15, 2011
1 – 4:00pm

Location: MDCH
1st floor Capital View Bldg
Conference Room B&C
201 Townsend Street
Lansing, Michigan 48913

Commissioners Present:

R. Taylor Scott, D.O
Olga Dazzo
David Behen
Joseph Hohner
Toshiki Masaki – Vice Chair
Mark Notman
Larry Wagenknecht, R.Ph.
Kimberly Ross – Jessup

Commissioners Absent:

Dennis Swan
Tom Lauzon
Robert Paul
Robin Cole
Greg Forzley, M.D. – Chair

Staff:

Beth Nagel – MDCH

Guests:

Bruce Wiegand
James Gartung
David Durkee
Cindy Schnetzler
Jason Werner
Angela Vanker
George Peterman
Christine Fend
Dana Green
Melissa Cupp
Tim Pletcher
Deb Mosher
Carol Parker
Michelle Maitland

Mary Hojnacki
Jeff Shaw
Dennis Olmstern
Andrea Walrath
Sam Naser
Hank Mayers
Harry Levins
Dan Armijo
Jeff Allison
Rebecca Blake
John Hazewinkel

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, September 15, 2011 at the Michigan Department of Community Health with eight Commissioners present including the Vice Chair.

A. Welcome

B. Review and Approval of 8-18-11 meeting minutes

1. Minutes of the 8-18-11 meeting were approved and will be posted to the HIT Commission website following this meeting.

C. Role of HIT Commission

1. **Review of Activities Matrix:** In response to a request from the previous HIT Commission meeting, Beth Nagel provided a spreadsheet that aligns the activities of the HIT Commission since 2006 with the roles and responsibilities of the Commission as outlined in Public Act 137-2006 that created the HIT Commission. Nagel explained that this spreadsheet is meant to be a tool to assist the Commission in developing agenda items or recommendations for the upcoming 2011 annual report. Nagel asked the Commission if they would like any other tools for the October discussion.
2. **Discussion:** The Commission asked Nagel to put more current activities at the bottom of the spreadsheet. The Commission discussed the need to be able to identify unmet needs. Some ideas were to hold more public input forums, to ask each representative to report on the needs of their stakeholder group, and to hold a strategic planning session.

D. Dashboard for MI HIT Initiatives

1. **Updated Dashboard:** Beth Nagel gave an overview of changes made to the MI HIT Dashboard based on the recommendations of the Commission at the previous meeting. Changes included listing the revision date on each initiative and adding a “goal” column.
2. **Discussion: Modifications and/or Revisions:** The HIT Commission noted that the current layout is succinct and clean, but also wanted a way to show more detail on the trend without making the layout overly complicated. To achieve this objective, the HIT Commission suggested adding a “previous” column to the data.

E. MiHIN Shared Services Update

1. **Progress & Forecast of Activity:** Tim Pletcher, the Executive Director of the MiHIN Shared Services outlined the activities of the MiHIN of the last month. These activities include reviewing sub-state HIE proposals for funding, developing a plan for defining future use cases, and continuing establishing the organizational foundation of the MiHIN. Pletcher shared the details of the next three sub-state HIEs that have applied for the sub-state HIE funding. Pletcher shared details about the activities that MiHIN expects to accomplish in the coming two months.
2. **Procurement:** Pletcher shared an overview of the procurement process and reviewed the steps that have been taken to arrive at the top two vendors. Pletcher discussed the due diligence process that has been performed, the current status and the process for moving forward to contracting with the finalist. Pletcher reviewed the technical model and the similarities between

this model and the majority of other states with Michigan's size, complexity and state of readiness.

3. **Discussion:** The HIT Commission asked if there had been any unexpected challenges with the contracting process. Pletcher said that MiHIN expected the process to be complex. HIT Commission members noted that they were pleased to see the progress and that MiHIN was moving forward.

F. MDCH's Strategic Priorities and Implementation Updates

1. Director of MDCH, Olga Dazzo, gave a presentation of the Department's priorities. This presentation was requested at the previous HIT Commission meeting. Dazzo presented the information that was in Governor Snyder's health message, which focused on health and wellness; access; healthcare reform; and improved governance. Dazzo discussed the upcoming obesity summit and infant mortality summit. Dazzo discussed Michigan's health dashboard, and the steps MDCH is taking to make improvements.
2. The HIT Commission expressed gratitude for hearing more about MDCH's priorities and noted that the approach is comprehensive. The HIT Commission discussed that throughout their deliberations they should be thinking how they can help MDCH reach these goals.

G. M-CEITA

1. **Altarum Response to HIT Commission Request for Information :** At the last HIT Commission meeting in August, the HIT Commission recommended that MDCH request more information about M-CEITA in the following areas: 1) the strategies to fill the leadership gap in the M-CEITA organizational structure, 2) the pricing structure including the methodology for discounts and 3) the risks and mitigation strategies. Dan Armijo from Altarum came to the HIT Commission meeting to provide an update on the program and answer the three questions, as follows:
 - i. Armijo outlined the organizational structure include that has been revised and includes a newly hired operations manager. Armijo explained that the focus of the program is now on the business and side and therefore would not be focusing on replacing the clinical director. Armijo indicated that this is consistent with the majority of other Regional Extension Centers around the nation.
 - ii. The pricing structure was outlined and Armijo explained that providers can pay between \$0 and \$500 for M-CEITA services. Discounts are given many reasons which include hardships, group purchasing discounts, level of service needed, and if there are learning opportunities for staff available at the site. The pricing discounts can be offered across all of the sub-contractors that serve the state.
 - iii. The risks and mitigation strategies for M-CEITA include 1) an ambitious timeline, which M-CEITA is mitigating by focusing on provider organizations to reach a mass quantity of providers most efficiently, 2) Provider confusion over all ARRA HIT initiatives, which M-CEITA is mitigating by maintaining coordination and

communication with the other initiatives. 3) Program sustainability, which M-CEITA will mitigate by having a full-time staff person dedicated to developing a sustainability plan.

2. **Discussion:** Some Commissioners expressed personal knowledge of providers that were happy with M-CEITA services. The HIT Commission asked if M-CEITA was tracking their attrition rate and Armijo said they are focused on the next two milestones but will start looking at attrition rate. Commissioners asked if M-CEITA will be successful in meeting the milestones and Armijo said that they are on target when compared to the rate of adoption seen nationally. Armijo added that since Medicare and Medicaid incentives are being paid out that the program expects to see an influx of participants. When asked about the biggest hurdles to providers, Armijo said that cost of the technology is a big barrier and that interface costs are one of the biggest factors driving the prices upward. The HIT Commission suggested that Altarum should provide this same presentation to the Statewide Stakeholder Committee.

H. Update on Long Term HIT Goals

1. **Update from Sub-Group:** Beth Nagel provided an update to the Commission on the background and progress made on developing recommended long-term HIT goals for Michigan. Nagel noted that the group has begun, but needs more members. Commissioners said they would respond by finding new members.

I. Commissioner Updates

1. Vice-Chair Masaki noted that the November HIT Commission meeting is canceled.

J. Public Comment

1. Hank Meyers asked if the dashboard will be on a website. Nagel replied that it would be soon, but the Commission was still adjusting the layout.
2. Deb Mosher noted that it wasn't just behavioral health that was left out of the Medicare and Medicaid EHR incentives – Long Term Care has also been largely excluded.

K. Adjourn

1. Meeting Adjourned at 3:25 p.m.



Michigan Health Information Technology Commission

September 15, 2011


The Michigan Health IT Commission is an advisory Commission to the Michigan Department of Community Health and is subject to the Michigan open meetings act, 1976 PA 267, MCL 15.261 to 15.275

Agenda

- A. Welcome & Introductions
- B. Review of 8-18-11 meeting minutes
- C. Role of the HIT Commission – Activities Matrix
- D. Dashboard for Michigan HIT Initiatives
- E. MiHIN Shared Services Update
- F. MDCH Strategic Priorities and Implementation Updates
- G. M-CEITA Update and Response
- H. HIT Commission Long Term Goal – Workgroup update
- I. Commissioner Updates
- J. Public Comment
- K. Adjourn

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Role of the HIT Commission


Review of Activities Matrix -- Beth Nagel, Vice Chair
Discussion -- Vice Chair, All

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Activities & Roles

- In order to set future direction and goals, HIT Commission asked for:
 - Completed activities & Roles and Responsibilities
- Attached matrix takes the roles outlined in PA 137, 2006 and looks at activities accomplished since the Commission was created.

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Role of the HIT Commission

- Goal of today's brief discussion:
 - Review the attached spreadsheet
 - Identify other resources needed to inform future discussions
- End goal at future meeting: Identify the areas where the Commission would like to concentrate or do further work

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Michigan HIT Dashboard

Overview -- Beth Nagel, MDCH

Discussion: Modifications, Revisions -- Chair, All

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Updated Dashboard

- **Most Areas Updated since August report:**
 - MiHIN
 - State of MI Public Health Reporting
 - Medicaid EHR Incentive Program
 - M-CEITA
 - Beacon
- **One Area will be updated quarterly:**
 - MI Sub-state HIEs

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Updated Dashboard

- **Changes from August Meeting:**
 - “Goal” column
 - “Trend” arrow is filled in for data that changed from the previous month’s update
 - HIT Workforce added a second measure for each community college re: “number of graduates placed in HIT related job”

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MiHIN

Michigan Health Information Network (MiHIN)		
Milestone	Status	Notes
Governance Created & Implemented	Green	creation and implementation complete and is fully operational
Technology Purchased and Implemented	Green	Procurement underway and on-schedule
Integration with State of Michigan HIE (SOMHIE)	Green	Dependent on Procurement and Implementation
Connect Sub-State HIEs to MiHIN Shared Services	Green	Dependent on Procurement and Implementation
Statewide HIE Available to Every MI Provider	Green	Funding for 2 sub-state HIEs has been approved by the ONC and ONC is reviewing three other proposals
Planning for Second Phase of Technology	Green	Planning underway
Financial Sustainability Identified & Implemented	Yellow	Planning process not yet determined

- **Note: MiHIN is on Today's agenda to discuss progress**

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State of MI Public Health Reporting

State of Michigan (SOM) HIE					Trend
Measure	Data	Goal	Status	Notes	
# of Eligible Professionals meeting MU for Public Health	413	29,302*	Green	Includes Immunization and Syndromic Surveillance	↑
# of Eligible Hospitals meeting MU for Public Health	42	174*	Green	Includes Immunization and Syndromic Surveillance	↑
Data sharing through a connection with MiHIN Shared Services			Green	Denominator: approximately 174 Connectivity planning is underway and hinges on MiHIN implementation	

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Medicaid EHR Incentives

Medicaid EHR Incentive Program Measure	Data	Goal	Status	Notes	Trend
# of Eligible Professionals receiving Medicaid Incentives	155	2,300	Green	started 8/11	↑
# of Eligible Hospitals receiving Medicaid Incentives	5	130	Green	started 9/1/11	↑
Amount of Federal Medicaid Incentive Funding Expended	9,572,057	\$40 million	Green		↑

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M-CEITA

Michigan Center for Effective IT Adoption (M-CEITA) Measure	Data	Goal	Status	Notes	Trend
# of Providers Signed Up to Use M-CEITA Services	2,695	3,724	Green	Goal is for Feb 2012	↑
# of Providers Go-Live on EHRs	736	1,380	Green	Goal is for Feb 2012	↑
# of Providers Reaching Meaningful Use	5	300	Yellow	Goal is for Feb 2012	↑

- Note: M-CEITA is on Today's agenda to discuss progress

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Beacon

Beacon Community Collaborative		
Milestone	Status	Notes
Clinical Transformation	Green	Activities include: 48 practice sites (36 min required), approx 120 PCPs and 13,500 patients (4000 min) for CT intervention engaged to date; patient navigators for patient engagement (roll-out of 4 PHNs w/40 patients to date; revising target of 800 patients by year end); planning mobile health campaign, pharmacy and ED intervention to launch in Q4
Information Technology	Yellow	Activities include: HIE procurement process, contracting, data sharing agreements, P&P, interfaces, pilots and operational HIE
Evaluation & Measurement	Green	Activities include: developing measures and survey tools, reporting quarterly, building environment for data housing
Communications & Outreach	Green	Activities include: developing communications plan, value propositions, and website
Scalability, Sustainability and Research	Green	Activities include: workgroups, sustainability plan, identify funding opportunities, develop scalability plan

- Note: Beacon is on the October agenda to discuss progress

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HIT Workforce

Midwest Community College HIT Consortium					
Measure	Data	Goal	Status	Notes	Trend
Lansing Community College students enrolled	75	200	Green		↑
Lansing Community College students placed in related jobs or current job expanded	2		Yellow	Voluntary reporting from students	
Macomb Community College students enrolled	95	300	Green		↑
Macomb Community College students placed in related jobs or current job expanded	19		Green	Voluntary reporting from students	
Delta College students enrolled	280	300	Green		↑
Delta College students placed in related jobs or current job expanded			Yellow	Voluntary reporting from students - not available, reporting started late	
Wayne Community College students enrolled	277	300	Green		↑
Wayne Community College students placed in related jobs or current job expanded	7		Green	Voluntary reporting from students	

- Note: The HIT workforce program is on the October agenda to discuss progress

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Discussion

- Changes?
- Modifications?
- Additional data?

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MiHIN Shared Services Update

- Progress & Forecast of Activity -- Tim Pletcher, MiHIN
- Sub-state HIE funding -- Tim Pletcher, MiHIN
- Procurement -- Tim Pletcher, MiHIN
- Discussion: Input to MiHIN? -- Vice Chair, All

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MICHIGAN HEALTH INFORMATION NETWORK

HIT Commission Update September 2011

MiHIN

Michigan Health Information Network

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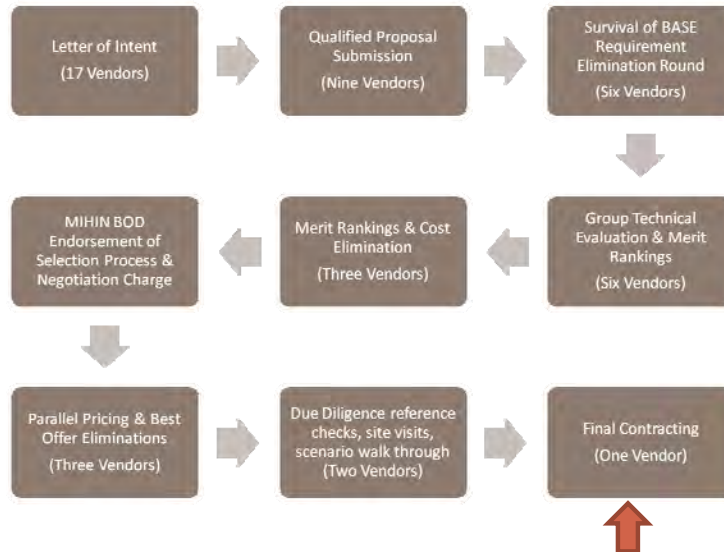
Status of Activities

Phase One RFP Contracting	August Sept, 2011	✖
Sub-State HIE Funding Awards	August Sept, 2011	✖
All Sub-State HIE Workshop	September, 2011	
Public Announcement of Final Vendor Award	September, 2011	
Detailed Phase One Implementation Planning	September, 2011	
Phase One Project Plan Ready	September/October, 2011	
Commence Future Use Case Discussions	September-October, 2011	

PHASE ONE REQUEST FOR PROPOSAL

Michigan Health Information Network

OVERVIEW OF THE RFP SELECTION METHODOLOGY



DRAFT Work-In-Progress DO NOT CITE or QUOTE

19 MiHIN
Michigan Health Information Network

RFP SELECTION PROCESS

OVERVIEW QUALIFIED ORGANIZATION FUNDING

Purpose: The State HIE Cooperative agreement calls for funding for Michigan's qualified sub-state HIEs to thrive, expand and keep costs affordable for providers seeking meaningful use.

Milestone Based Payments: Each sub-state HIE will have the opportunity to submit one proposal for funding with a cap of \$250,000. Based on the discretion of the MiHIN Board, a sub-state HIE can apply for a second award based on funding availability within the budget approved by the Office of the National Coordinator for HIT ("ONC")_ for sub-state HIEs. Milestones will be used to stage payments.

Eligibility: A sub-state HIE is considered eligible if it can demonstrate that it is working toward the criteria outlined in the approved MiHIN Shared Services Strategic Plan on pages 31 and 32 and is specifically named in the MiHIN Shared Services Strategic and Operational Plan Amendment posted at www.michigan.gov/mihin.

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Michigan Health Information Network

ABOUT THE MICHIGAN HEALTH INFORMATION NETWORK

ACTIVITIES REQUESTED

My1HIE (\$250K)

- Addition of an MPI and CDR to the architecture to support the aggregation of patient data from multiple sources, and to enable a more comprehensive patient care summary that can be shared by unaffiliated organizations through the community view of the dashboard including integration of point-of-care alerts based on the more complete patient record.
- Enhancements to the existing physician portal to support a Community View of patient data in a consolidated dashboard, with support for break-the-glass workflow and audit trail. It will also enable provider-selected CCD based data extraction from the dashboard into a physician or hospital EMR to support transitions of care across unaffiliated organizations.
- Expansion of the Messaging Hub to support additional data sources and data types (such as EMR interfaces to and from the portal and registry)

UPHCN (\$250K)

- UPHCN is requesting \$250,000 to help augment the cost of selecting & implementing a HIE technology vendor to support the vision as stated for the UPHIE. As stated in the UPHIE Strategic Plan, hospitals and providers are not positioned to be able to meet Meaningful Use requirements with regional health information exchange capabilities. The funding requested would be used to implement the vision of the UPHIE and impact all of the health care providers in the Upper Peninsula.

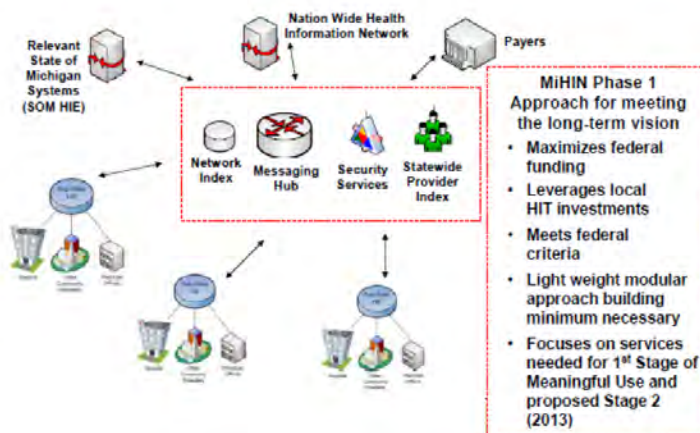
MiHIN

Michigan Health Information Network

SUB-STATE HIE FUNDING REQUESTS

PHASE ONE

MiHIN Shared Services Phase 1:



MiHIN

Michigan Health Information Network

MIHIN SHARED SERVICES

INITIAL SERVICES

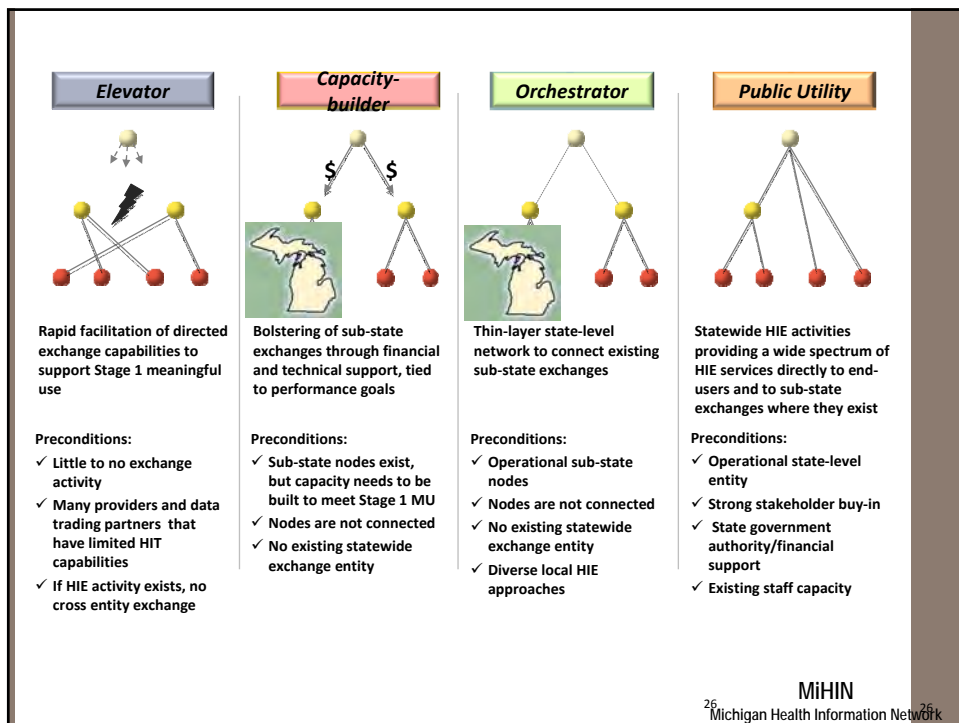
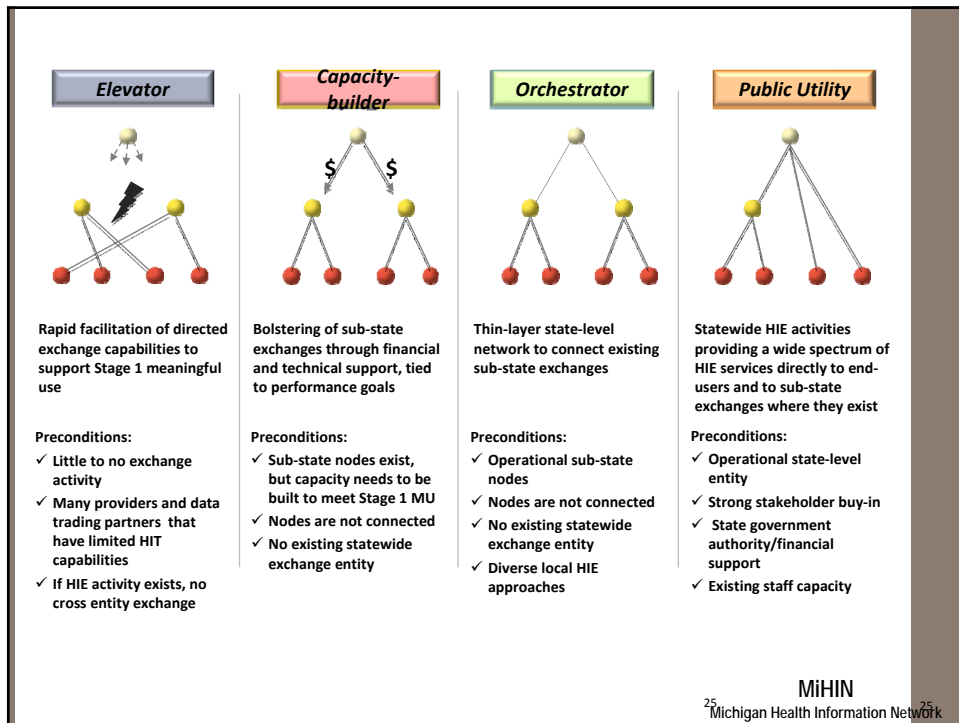
1. Security and Messaging Services: Allows secure transaction-based routing among an index of qualified organizations (Sub-State HIEs, State of Michigan HIE, and NwHIN) and ensures that MiHIN has mechanisms to transform, translate, and transport data in multiple standard formats.
2. Master Provider Index: Provides an integration point for entity level and individual level identification providers and the various ID's used by different systems to uniquely identify providers.
3. NWHIN Gateway: Provides for a single statewide implementation of the CONNECT and NWHIN Gateway for authorized exchange of clinical information across NWHIN.

INITIAL USE CASES

USE CASE: A Use Case is a description of a scenario or the steps required to enable a useful interaction among “actors” to accomplish a task or function. Use Case are a very common way help define what an application will do.

MiHIN is focused on Two General Use Cases:

1. Electronic Public Health Reporting
 - a. Pushing immunization records into the Michigan Care Improvement Registry (MCIR).
 - b. Pushing reportable labs into the Michigan Disease Surveillance System (MDSS)
2. Push of Structured Data
 - a. Lab Results & Care Summaries (CCD or CCR's)



info@MiHIN.ORG

See: WWW.MIHIN.ORG

MiHIN
Michigan Health Information Network



MDCH Strategic Priorities & Implementation Progress

Olga Dazzo,
Director, MDCH



Michigan Department of Community Health

Director Olga Dazzo

Creating DCH 3.0

HIT Commission Meeting
September 15, 2011

Health Care Reform – White Paper

“Michigan’s citizens should have access to the highest quality care available. As Governor, I will manage rising costs by implementing innovative management strategies, expand access through community based solutions, and promote wellness programs that identify health problems before they become chronic or more serious.” ~ Governor Rick Snyder

1. Promote wellness programs to reduce costs, improve quality of life, detect illness early.
2. Create Patient-Centered Medical Homes for Medicaid populations .
3. Increase Medicaid reimbursement rates.
4. Use Federally Qualified Health Centers to increase access and reduce costs.
5. Leverage community solutions for high-risk populations.
6. Implement Health IT initiatives to reduce administrative costs, enhance fraud protection, and eliminate costly redundant testing.



Our Vision: DCH 3.0

***Improve Health, Improve Care, Lower Costs
Through Competitive and Collaborative
Organized Systems of Care***



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Strategic Priorities January 2011 – December 2011

1. Improve the health of our population:

- a. Implement statewide stakeholder plan for obesity. (Chabut)
- b. Implement statewide stakeholder plan for infant mortality. (Chabut)

2. Improve the health care provided to our population:

- a. Implement patient-centered medical home demonstration grant. (Fitton)
- b. Be a catalyst to create OB services access in northeast Michigan. (Chabut)
- c. Develop plan to promote FQHCs in the state. (Brim)
- d. Implement plan to promote integration of behavioral and physical health, including health homes (ACA 2703). (Zeller)

3. Lower the health care costs per person in our State:

- a. Obtain grants from foundations for statewide planning: obesity, infant mortality, health system reform, FQHCs. (Brim)
- b. Implement Office of Health Inspector General to reduce fraud, waste, abuse. (Hill)
- c. Develop and implement internal audit plan with links to OHIG, DTMB, DHS, Auditor General, CMS. (Lyon)
- d. Move fee for service programs into managed care.
 - a. Children with special health care needs. (Fitton)
 - b. Medicare and Medicaid Dual Eligibles. (Fitton)
- e. Implement 2012 Budget. (Lyon)

4. Plan and implement health care reform if feasible:

- a. Implement multidisciplinary bureau that focuses on planning and implementing health reform. (Priest)
- b. Plan expansion of Medicaid to 133% of FPL. (Priest)
- c. Complete health insurance exchange plan design and consider conclusions for implementation. (Priest)
- d. Obtain planning grant for integration of dual eligibles and implement. (Fitton)
- e. Implement 2013 and 2014 physician fee schedule increase to 100% of Medicare. (Fitton)
- f. Expand Aging and Disability Resource Centers. (Sederburg)
- g. Expand long term care option counseling through Community Living Program. (Sederburg)
- h. Identify other health reform opportunities that meet Gov. Snyder's reform goals. (Priest)



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Strategic Priorities January 2011 – December 2011

1. Improve the health of our population (Chabut):

- a. Implement statewide stakeholder plan for obesity.
(Summit: September 21, Lansing Center)
- b. Implement statewide stakeholder plan for infant mortality.
(Summit: October 17, Marriott Ann Arbor, Ypsilanti)



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Michigan Dashboard: Obesity, Infant Mortality



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Health and Social Impact

- Major cause of morbidity and mortality
 - Lack of physical activity and poor nutrition combined is the second leading cause of preventable death
 - Contributes to major chronic conditions - heart disease, hypertension, stroke, type 2 diabetes, asthma, certain cancers, arthritis, depression, dementia
 - Adults and children are developing obesity related chronic conditions

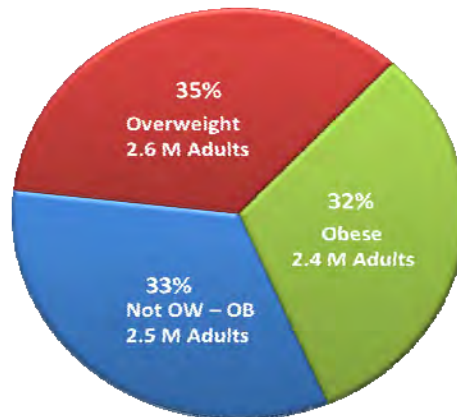


Economic Impact

- Economic costs of obesity are staggering
 - In 2008, Michigan spent an estimated \$3.1 billion in obesity related medical costs
 - Michigan is expected to spend \$12.5 billion in obesity medical costs in 2018



Michigan Adult Population 2010 Weight Status 7.5 Million Persons > 18 years of age



2010 Census Data
Total Population 9.8 Million
> 18 years of age 7.5 M, 76.4%
< 18 years of age 2.3 M, 23.6%

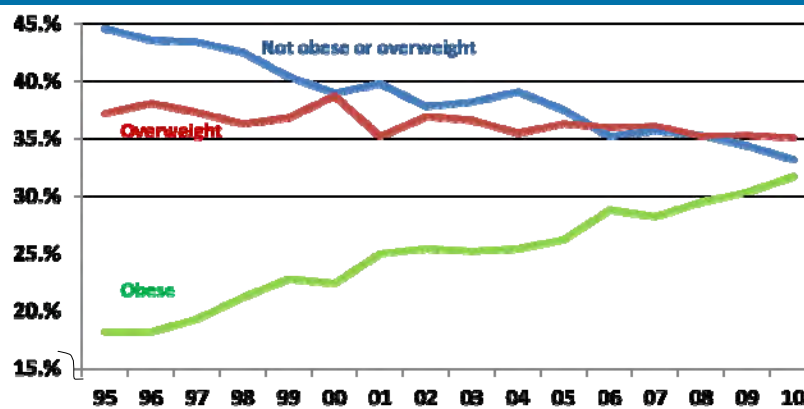
Source: BRFSS Survey 2011



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Michigan: Call to Action Adult Weight Status (>18 years of age)



Obese: BMI >30 **Overweight:** BMI >25 <29.9 **Not Obese or Overweight:** BMI <24.9

Source: BRFSS Survey, 2011



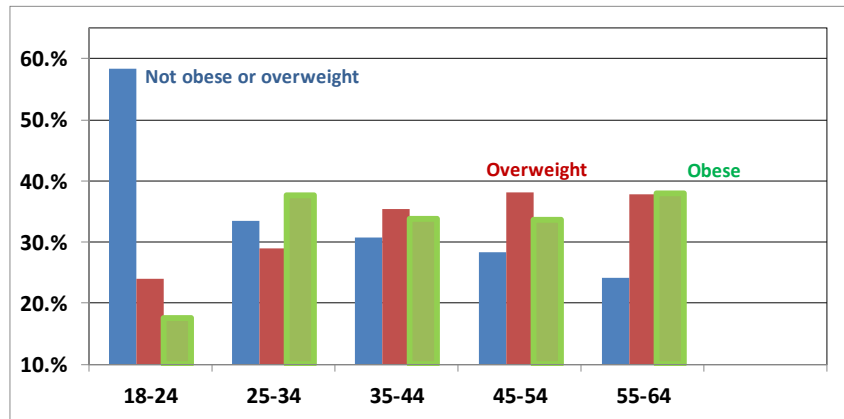
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Michigan: Call to Action

Adult Weight Status 2010 by Age Cohort

(>18 years of age)



Obese: BMI >30 Overweight: BMI >25 <29.9 Not Obese or Overweight: BMI <24.9
Source: BRFSS Survey



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Michigan's Ranking

10th Fattest State

	White		Black		Hispanic		Other	
	OW/ OB %	%	OW/ OB %	%	OW/ OB %	%	OW/ OB	%
U. S.	63	65	74	12	69	16	n/a	7
Michigan	66	77	74	14	68	4	n/a	5

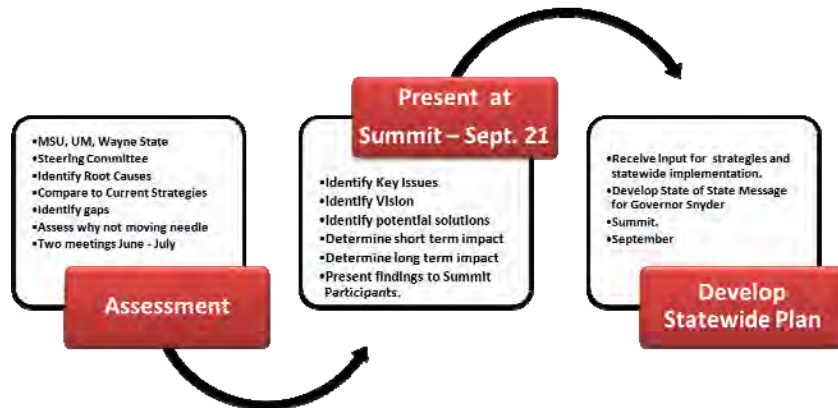
Source: KFF website
2010 comparisons



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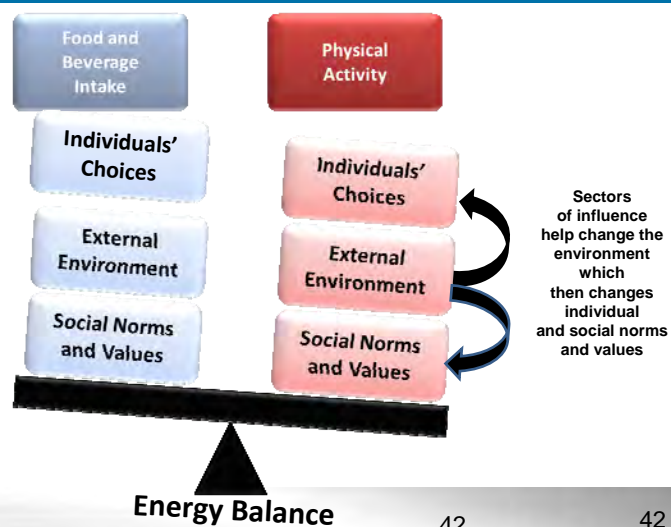
NEED YOU: SEPT. 21, LANSING CENTER



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Health Management Challenge and Social Ecology Model



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Sectors of Influence

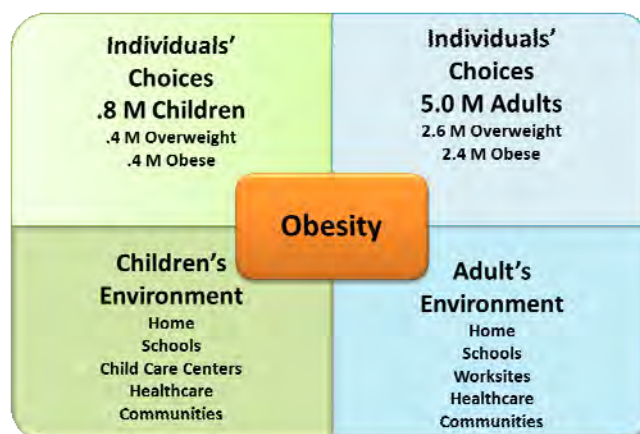
- Food and beverage industry
- Agriculture
- Education
- Media
- Legislature
- Government: federal, state, local
- Public health systems
- Healthcare industry (delivery and financing)
- Weight management programs
- Business and workers
- Labor unions
- Land use and transportation
- Leisure and recreation
- Churches
- Employers large and small
- Trade organizations
- Service organizations
- Technology companies
- Universities
- All DCH administrations



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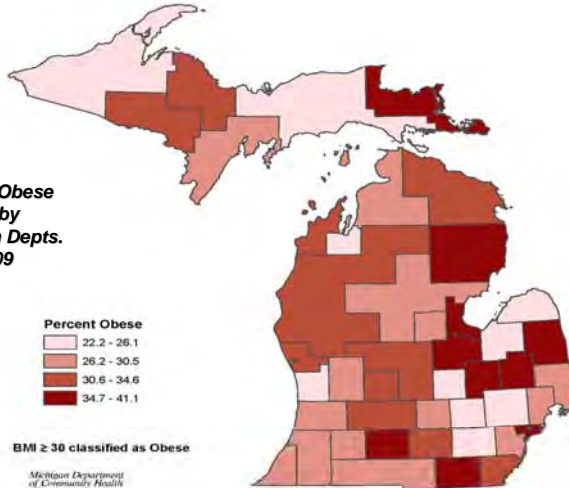
Opportunities for Intervention In Michigan



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Need Critical Mass Interventions

Percent of Obese Adults by Local Health Depts. '07 - '09



Henry Miller, November 24, 2010

Data source: Preliminary Michigan Behavior Risk Factor Survey 2007 - 2009 Combined
MDCH Chronic Disease Epidemiology Section

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Current Michigan Strategies

Policy, Environmental, Systems Change

- Healthy Kids, Healthy Michigan
- Healthy Communities
- Complete Streets

School-based, Child Care Programs

- Nutrition Standards
- Safe Routes to School
- Child care
- Head Start
- Health, Physical Education

Health Disparity Reduction Projects

- Faith-based Nutrition and Physical Activity Project
- Healthy Hair Starts with a Healthy Body/Dodge the Punch

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Michigan's Obesity Movement

The diagram illustrates the Michigan's Obesity Movement as a complex network of interconnected organizations. At the center of the network are five red star-shaped nodes, each representing a state agency: MDARD, MSHDA, MDCH, DHS, and DNR. Surrounding these central nodes are numerous blue circular nodes, each representing a different organization. These organizations are connected to the central nodes and to each other by a web of lines, indicating a highly interconnected network. The organizations include:

- Michigan Association for Health, Physical Education, Recreation, & Dance
- American Cancer Society
- Local Public Health Departments
- Michigan Association for Local Public Health
- Black Mother's Breastfeeding Association
- Michigan Health & Hospital Association
- Michigan Association of Planning
- Michigan Recreation & Park Association
- Kellogg Foundation
- Michigan Association for the Education of Young Children
- Inter-Tribal Council of Michigan
- Michigan Trails and Greenways Alliance
- Michigan Public Health Institute
- Michigan Land Use Institute
- MI Chapter American Academy of Pediatrics
- Michigan Grocers Association
- Michigan Breastfeeding Network
- Blue Cross Blue Shield of Michigan
- Detroit Economic Growth Corporation
- Michigan Farmers Market Association
- Early Childhood Investment Corporation (ECIC)
- League of Michigan Bicyclists
- Michigan Fitness Foundation
- Institute for Black Family Development
- United Dairy Industry of Michigan
- YMCA
- American Heart Association
- Universities/Colleges
- Altarum Institute
- Michigan Head Start Association
- MI Economic Development Corp
- Michigan Association of Planning
- Michigan Health & Hospital Association
- Black Mother's Breastfeeding Association
- Michigan Association for Local Public Health
- Michigan Association for Health, Physical Education, Recreation, & Dance
- American Cancer Society
- Local Public Health Departments

Strategic Priorities

January 2011 – December 2011

2. Improve the health care provided to our population:

- a. Implement patient-centered medical home demonstration grant. (Fitton)
- b. Be a catalyst to create OB services access in Michigan. (Chabut)
- c. Develop plan to promote FQHCs in the state. (Brim)
- d. Implement plan to promote integration of behavioral and physical health, including health homes (ACA 2703). (Zeller)



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- a. **Implement patient-centered medical home demonstration grant. (Fitton)**
- b. **Be a catalyst to create OB services access in Michigan. (Chabut)**
- c. **Develop plan to promote FQHCs in the state. (Brim)**
- d. **Implement plan to promote integration of behavioral and physical health, including health homes (ACA 2703). (Zeller)**

Strategic Priorities January 2011 – December 2011

3. Lower the health care costs per person in our State:

- a. Obtain grants from foundations for statewide planning: obesity, infant mortality, health system reform, FQHCs. (Brim)
- b. Implement Office of Health Inspector General to reduce fraud, waste, abuse. (Hill)
- c. Develop and implement internal audit plan with links to OHIG, DTMB, DHS, Auditor General, CMS. (Lyon)
- d. Move fee for service programs into managed care.
 - a. Children with special health care needs. (Fitton)
 - b. Medicare and Medicaid Dual Eligibles. (Fitton)
- e. Implement 2012 Budget. (Lyon)



Strategic Priorities January 2011 – December 2011

4. Plan and implement health care reform if feasible:

- a. Implement multidisciplinary bureau that focuses on planning and implementing health reform. (Priest)
- b. Plan expansion of Medicaid to 133% of FPL and explore basic health plan. (Priest)
- c. Complete health insurance exchange plan design and consider conclusions for implementation. (Priest)
- d. Obtain planning grant for integration of dual eligibles and implement. (Fitton)
- e. Implement 2013 and 2014 physician fee schedule increase to 100% of Medicare. (Fitton)
- f. Expand Aging and Disability Resource Centers. (Sederburg)
- g. Expand long term care option counseling through Community Living Program. (Sederburg)
- h. Identify other health reform opportunities that meet Gov. Snyder's reform goals. (Priest)



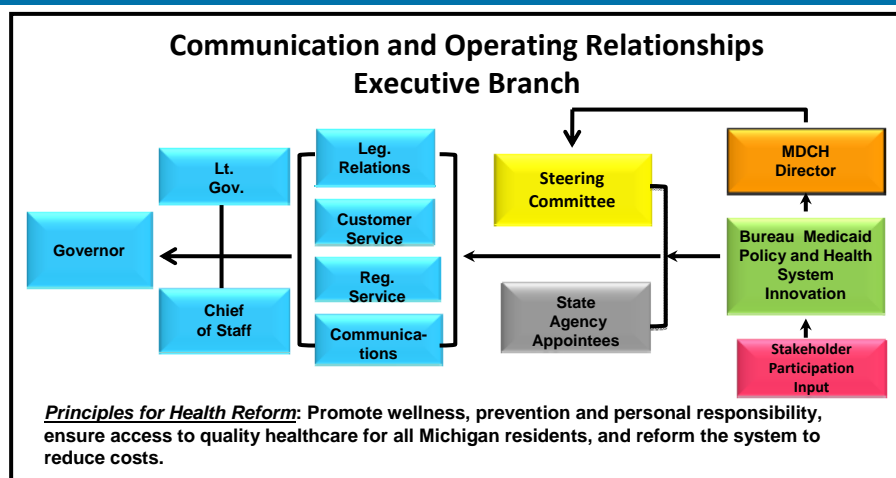
Healthcare Reform Implementation to Date



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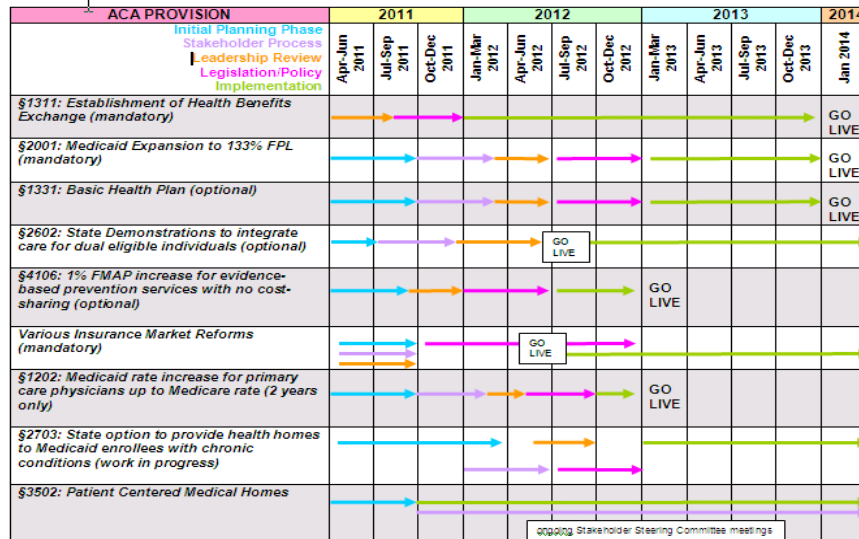
Health Reform Operating Planning Model



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Health Care Reform Planning Timeline

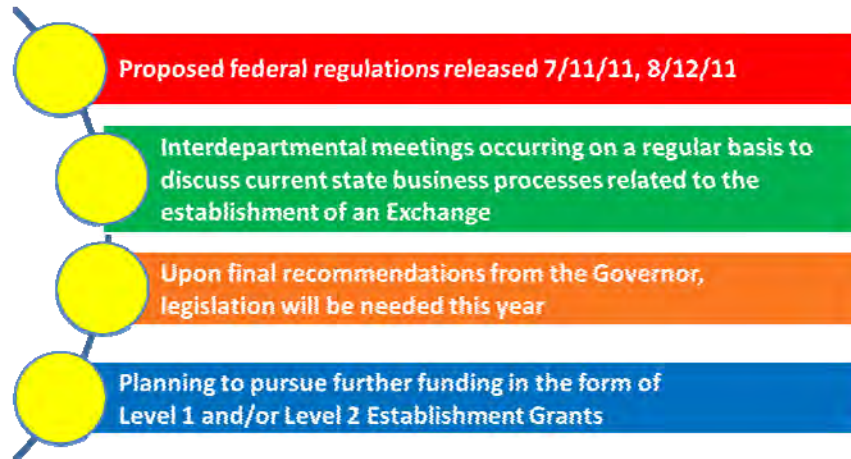


Health Insurance Exchange: Progress to Date

- ✓ Five Stakeholder Workgroups were convened between February and April to discuss policy issues and make recommendations
- ✓ Workgroups made over 50 consensus-based recommendations
- ✓ Stakeholder recommendations compiled into a report for distribution to the Steering Committee, Legislature, others
- ✓ A Steering Committee of leadership from 9 state agencies reviewed the stakeholder findings and is making final recommendations to the Governor



Health Insurance Exchange: Next Steps



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Integrating Care for Dual Eligibles

- DCH awarded nearly \$1 million in planning funds from CMS to develop Integrated Care over the next year
- Key Objectives
 - Improve quality of care and access to care for people eligible for both Medicaid and Medicare
 - Fully integrate Medicare and Medicaid program rules and funding with shared savings
- Stakeholder process
 - Under way
 - integratedcare@michigan.gov
 - <https://janus.pscinc.com/dualeligibles>



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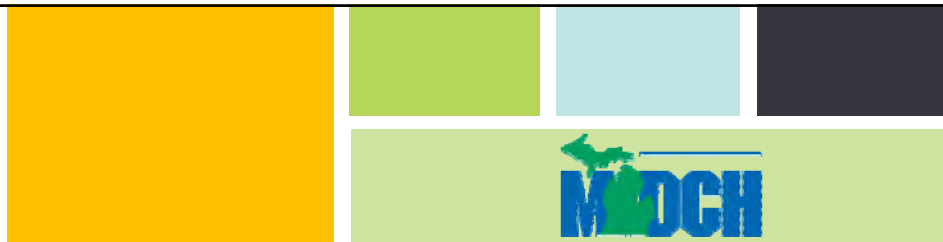
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Michigan Department of Community Health

Director Olga Dazzo

Thank You!



M-CEITA Update

Altarum Program Update and Response to
HIT Commission Request for Information -- Dan Armijo

Discussion: New recommendations or
feedback for statewide stakeholder
committee? -- Vice Chair, All



Michigan's Health IT Regional Extension Center: M-CEITA

*Report to the Michigan Department of Community Health &
Michigan Health Information Technology Commission*

September 2011

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Topics Covered

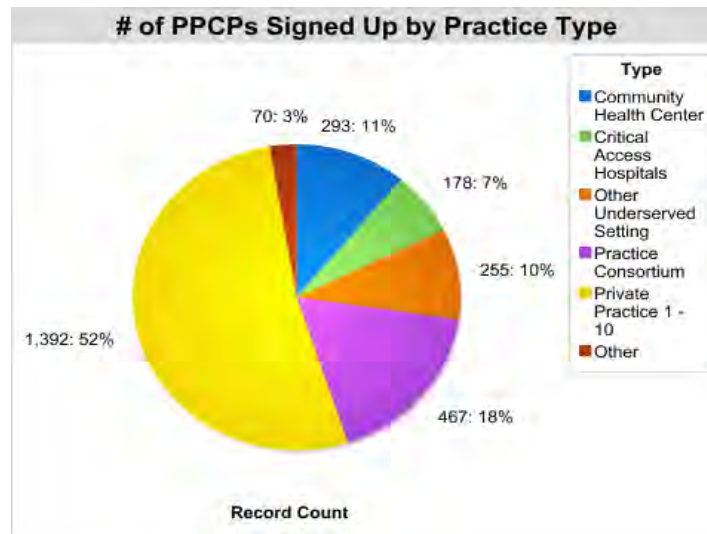
- **Program Milestones**
- **Program Leadership**
- **Program Pricing**
- **Risks and Mitigation Strategies**
- **EHR CBA**
- **Activity Update**
- **Finance Update**

M-CEITA Practice Type and Location as of September 9, 2011

M-CEITA
is currently
working
with **2,687**
providers across
the state!

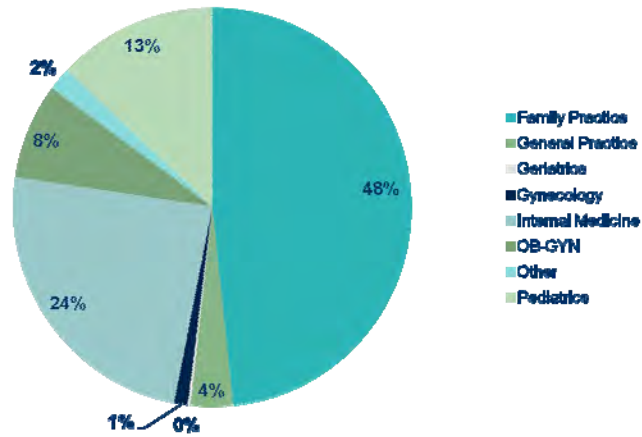


M-CEITA Provider Statistics



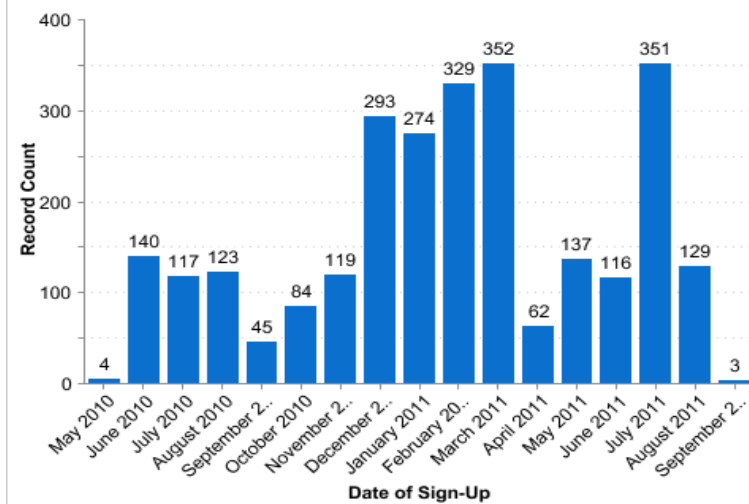
M-CEITA Provider Statistics

PPCPs Signed up by Specialty

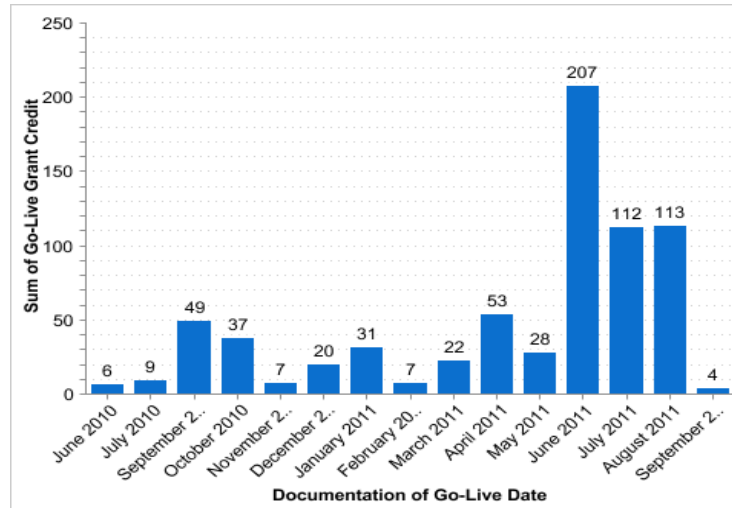


Milestone 1: Provider Sign-up

of Providers Signed Up by Month

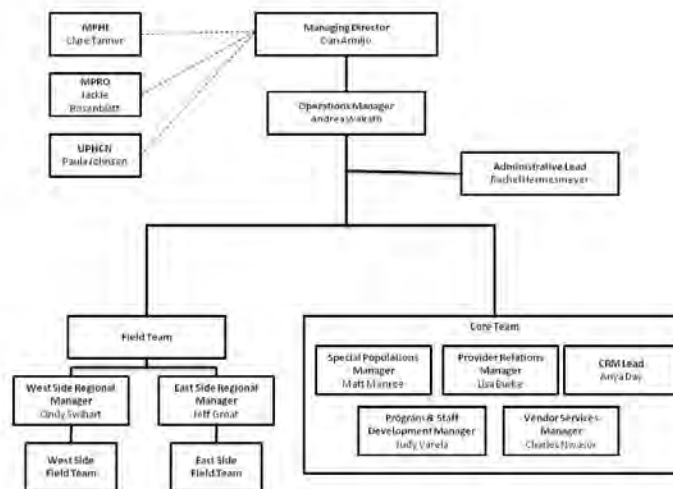


Milestone 2: EHR go-live or modular bundle (quality reporting and e-prescribing)



M-CEITA Leadership Update

- Operations Manager Andrea Walrath hired in August



M-CEITA Pricing and Discounts

- \$0 to \$500 per provider
- Our pricing is based on the following:
 - (1) Financial hardship
(% Medicaid, underserved setting, etc.)
 - (2) Volume purchases
e.g. Physician organizations, health plans
 - (3) Scope of services
Full scope versus supporting only attestation
Level of effort sharing from partnering org (POs)
 - (4) Level of adoption at the practice
i.e. Can M-CEITA staff learn from that practice's experience

Program Risks and Mitigation Strategies

- Aggressive timeline to fulfill program recruitment goals
 - Over 75% of Michigan providers belong to a PO, many of which are already making IT investments
 - Working closely with PO organizations to address multiple providers at once, offering volume discounts and reciprocal learning programs
- REC, HIE, Beacon, Medicaid incentive program all hitting providers at the same time, resulting in confusion
 - Do a better job of coordinating messages to these providers, with support from the HIT Commission
- We need to quickly triage practices after sign-up
 - Close collaboration with Sub-recipients, monitoring engagement times.
- Program sustainability
 - Dedicated staff to program sustainability
 - Active participating in ONC Sustainability CoP

EHR Cost-Benefit Analysis

- EHR adoption comes with significant risks (*Harsh et al.*)
- We've created an EHR Vendor Selection tool that takes into account not just functionality and price, but also risk
- One major decision point: Onsite vs. SaaS
- Altarum staff researched the following questions:
 - What are the differences in costs between deployment options?
 - What is the timeline of costs and benefits?
 - When do EHRs begin to pay for themselves?
 - How do incentive payments affect the EHR investments?
- Findings:
 - Due to greater upfront costs of onsite deployment, ROI changes significantly with practice size
 - Incentive payments noticeably reduce the break-even point for the investment

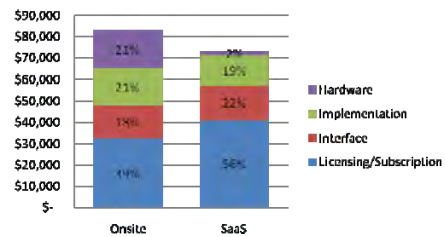
Data sources

- Detailed price quotes from 16 products
- Hardware purchase costs from Dell using vendor-supplied requirements
- Benefit data from Miller et al. *The Value Of Electronic Health Records In Solo Or Small Group Practices*
- Medicare/Medicaid EHR Incentive payment schedule

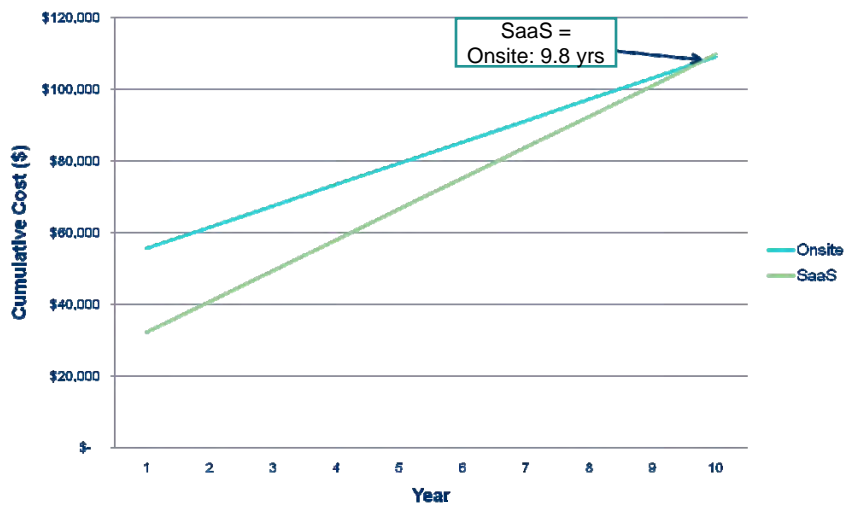
Cost categories and assumptions

- Year 1 costs
 - Licensing/Subscription
 - Interfaces
 - Assuming 3 interfaces
 - Implementation (installation & training)
 - Hardware
 - Assumed some existing infrastructure (workstations), assuming server acquisition necessary for Onsite
 - Reqs per vendor: Wireless access, router, printer, doc scanner, etc.
- Recurring costs
 - Licensing/Subscription
 - Interface maintenance and support
 - Infrastructure
 - Maintenance and refresh

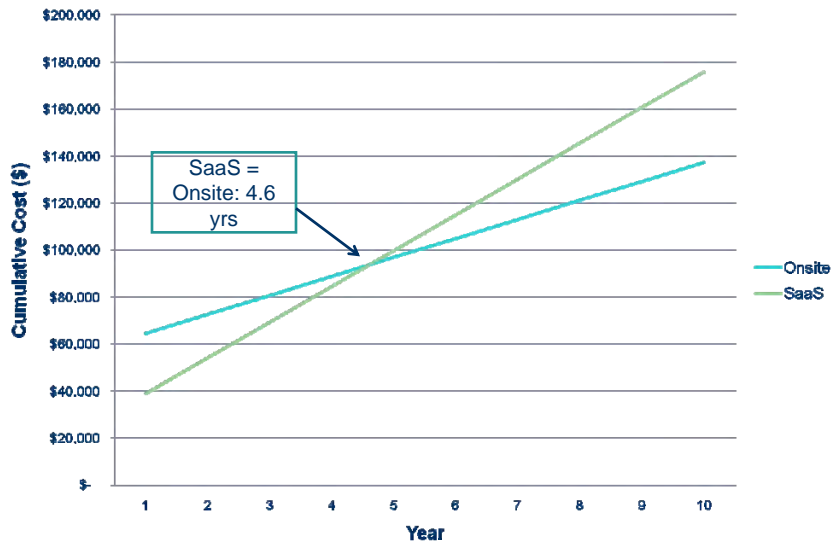
Costs by Type, 1 Provider, 5 yr TCO



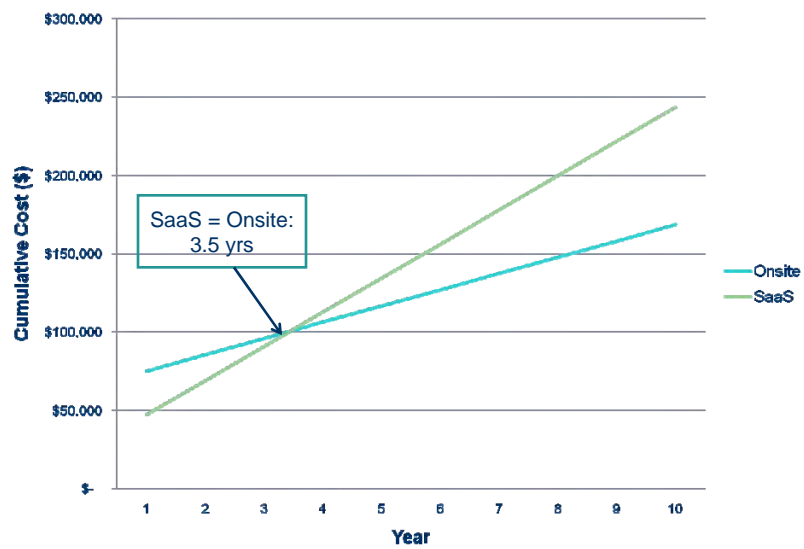
Cumulative Cost Profile for 1 Provider Office



Cumulative Cost Profile for 2 Provider Office

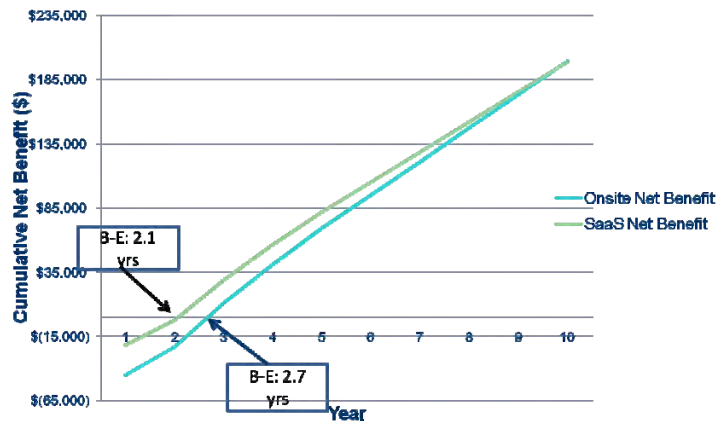


Cumulative Cost Profile for 3 Provider Office



Cumulative Net Benefit for 1 Provider Office Assuming 5-yr Phased Benefit Realization (Medicare/Miller)

Year	Miller Benefit	Full Medicare Benefit	Full Medicare+Miller Benefit
1	-7500	18000	10500
2	16000	12000	28000
3	32000	8000	40000
4	32000	4000	36000
5	32000	2000	34000



Activity Update: First M-CEITA Practice to attest to meaningful use

Health Specialists of Lenawee

- 6 physician practice serving ~100,000 patients in Lenawee County
- Began 90-day attestation period in April
- All providers attested by August
- CEO Doris Goodlock discovered M-CEITA through a presentation we gave at a local hospital system

"When we first decided to go for meaningful use, I thought we were ready. But there were so many little roadblocks and issues. Nothing major, but just things we wouldn't have known how to figure out without an expert."

- M-CEITA advocated with EHR vendor on their behalf to obtain the advertised software functionality, necessary for MU

Activity Update:

• Outreach & Education

- Website updates, in-person meetings, conferences, presentations
 - Ongoing with focus on continuous quality improvement
 - Public Health Administrator Seminar – M-CEITA presented September 9th – Mt. Pleasant
 - ONC Market Segmentation Workgroup – M-CEITA presenting September 15th – national webinar
 - Healthcare for the Homeless Conference – M-CEITA presenting September 20th – Southfield
 - OmniCare Health Plan Provider Orientation Meeting – M-CEITA presenting – September 27th

• Recruitment

- Currently M-CEITA is at **72%** of total M1 goal
- Plan to meet M1 goal by December 31, 2011
- UOP provider fax blast

• New Strategic Partners

- OmniCare; United Physicians; IHA

Activity Update:

• Vendor Update

- MCEITA focus on protecting providers, limiting risk
- Two key provisions have proved challenging for vendors, slowing contractual agreements:
 - Added security and privacy provisions
 - Revised limitations on liability - vendors cannot limit liability below any penalties imposed by the OCR

• Training

- All licensed users completing ONC DreamTeam training (Altarum only)
- Recommended online list of appropriate classes for REC staff available on HITRC
- Expanded field staff new hire training program

Upcoming Key Activities

- Ongoing recruiting and hiring for additional field staff
- Additional strategic partnerships to accelerate recruiting / Milestone achievement
- Field Staff full utilization of ONC project management tool
- Focus on targeting PCMH nominated and designated providers, who often have significant IT adoption
- Workforce
 - Proposed internship opportunities for HIT program students to be shared soon with Community Colleges
 - 4 weeks, 20 hours per week
 - Half time in the field working in provider offices alongside field staff ; the other half focused on core program activities.
 - Security risk analysis and IT assessments at provider offices included.

Finance Update – through August 2011

Core Funding – 2 year Budget

Total value: \$1,500,000

Total expended:	\$	1,225,126
Total remaining:	\$	274,874

	Incurring
Altarum	\$ 1,179,203
MCRH	\$ 31,735
MAFP	\$ 16,000

Direct Funding – 4 year Budget*

Total de-restricted value: \$7,718,070**

Total expended:	\$	4,904,854
Total remaining:	\$	2,813,216

	Incurring
Altarum	\$ 3,482,903
MPRO	\$ 589,131*
MPHI	\$ 584,250*
UPHCN	\$ 248,570*

*Does not include outstanding invoices

**Total contract ceiling: \$18,551,990

Finance Update – through August 2011

Kresge Grant

Total value: \$1,000,000	
Total expended:	\$ 858,166
Total remaining:	\$ 141,834

	Incurred
Altarum	\$ 356,142
MPRO	\$ 246,851
MPHI	\$ 249,928
Dennis Paradis	\$ 5,246

Provider Sign Up

Fees received:	\$ 304,475
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Match

Total committed:	\$ 3,383,629
Total incurred:	\$ 2,180,701

	Committed	Incurred
Altarum	\$ 1,309,026	\$ 488,171
MPRO	\$ 274,088	\$ 30,993
MPHI	\$ 253,866	\$ 26,466
UPHCN	\$ 296,649	\$ 137,340
BCBSM	\$ 250,000	\$ 639,565
Kresge	\$ 1,000,000	\$ 858,166

Progress on HIT Long Term Goals Workgroup

Progress & Next Steps -- Beth Nagel

Long Term Goals

- At the June 16, 2011 HIT Commission Meeting:
 - The Michigan HIT Commission resolves to create a sub-committee that is focused on long-term measures of the impact of health information technology.
 - The sub-committee should focus on leveraging existing efforts that measure the broad impact of cost, quality and access. The sub-committee should convene and gather information within the next quarter.
 - The motion passed with zero abstentions.

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Long Term Goals Workgroup

- Update:
 - HIT Commissioners nominations:
 - Kate Wodecki – BCBSM
 - Tim Pletcher – MiHIN
 - Beth Nagel – MDCH
 - Initial set of measures gathered from MQIC (HEDIS and CAHPS)
 - Group welcoming more members
 - Group reviewing other sources of data
 - Initial set of measures expected later this fall

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Commissioner Updates

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Public Comment

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Adjourn

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